FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018150

Facility Name: McLean County Nursing Home

Address: 901 North Main Street (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 888-5380 Fax # (309) 454-4594

IDPA ID Number:

Date of Initial License for Current Owners: 10/1/1971

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Donald Lee Telephone Number: (309) 888-5380

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Donald Lee
(Title) Administrator

Paid Preparer

(Signed) March 26, 2004 (Date)
(Print Name and Title) Mr. Robert Rein, Practitioner
(Firm Name & Address) Robert Rein CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,572	1,840	2,735	6,147	8
9	SNF/PED					9
10	ICF	27,826	16,093		43,919	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,398	17,933	2,735	50,066	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/1/1971 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,735

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [x] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	295,610	23,805	9,852	329,267		329,267		329,267			1
2	Food Purchase		282,998		282,998		282,998	(29,881)	253,117			2
3	Housekeeping	167,733	30,670		198,403		198,403		198,403			3
4	Laundry	108,770	29,453		138,223		138,223	(6,063)	132,160			4
5	Heat and Other Utilities			212,207	212,207		212,207		212,207			5
6	Maintenance	113,154	40,236	16,506	169,896		169,896	4,684	174,580			6
7	Other (specify):*											7
8	TOTAL General Services	685,267	407,162	238,565	1,330,994		1,330,994	(31,260)	1,299,734			8
	B. Health Care and Programs											
9	Medical Director			675	675		675		675			9
10	Nursing and Medical Records	2,092,228	12,398	161,166	2,265,792		2,265,792		2,265,792			10
10a	Therapy			143,788	143,788		143,788		143,788			10a
11	Activities	81,003	2,173	1,450	84,626		84,626		84,626			11
12	Social Services	83,167	491	1,450	85,108		85,108		85,108			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,256,398	15,062	308,529	2,579,989		2,579,989		2,579,989			16
	C. General Administration											
17	Administrative	91,894		60,488	152,382		152,382	(11,858)	140,524			17
18	Directors Fees							22,576	22,576			18
19	Professional Services			9,362	9,362		9,362	154,263	163,625			19
20	Dues, Fees, Subscriptions & Promotions			22,315	22,315	670	22,985	(670)	22,315			20
21	Clerical & General Office Expenses	122,413	19,384	31,535	173,332	(670)	172,662	(9,635)	163,027			21
22	Employee Benefits & Payroll Taxes			748,597	748,597		748,597		748,597			22
23	Inservice Training & Education					663	663	(465)	198			23
24	Travel and Seminar			3,678	3,678	(663)	3,015		3,015			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,270	11,270		11,270		11,270			26
27	Other (specify):*											27
28	TOTAL General Administration	214,307	19,384	887,245	1,120,936		1,120,936	154,211	1,275,147			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,155,972	441,608	1,434,339	5,031,919		5,031,919	122,951	5,154,870			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number McLean County Nursing Home #0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			182,633	182,633		182,633	1,979	184,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			182,633	182,633		182,633	1,979	184,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,501		129,501		129,501		129,501			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		129,501	82,125	211,626		211,626		211,626			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,155,972	571,109	1,699,097	5,426,178		5,426,178	124,930	5,551,108			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(490)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,979	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		21.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(46,224)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (44,735)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	169,665		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 169,665		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 124,930		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Lawn Service	$	City of Normal		$ 4,684	$ 4,684	1
2	V	18	County Board		McLean County	100.00%	22,576	22,576	2
3	V	19	Information Services		McLean County	100.00%	6,828	6,828	3
4	V	17	County Administrator	60,488	McLean County	100.00%	48,630	(11,858)	4
5	V	19	County Auditor		McLean County	100.00%	49,651	49,651	5
6	V	19	County Treasurer		McLean County	100.00%	97,784	97,784	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 60,488			$ 230,153	$ * 169,665	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: McLean County Government
Street Address: 104 West Front Street
City / State / Zip Code: Bloomington, IL 61702
Phone Number: (309) 888-5110
Fax Number: (309) 888-5111

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	County Board	Expenditures	100,000	49 Funds	$ 186,749	$ 66,195	12,089	$ 22,576	1
2	19	Information Services	% of Effort	100,000	49 Funds	1,465,302	664,916	466	6,828	2
3	17	County Administrator	FTE	100,000	49 Funds	470,492	255,618	10,336	48,630	3
4	19	County Auditor	Transactions	100,000	49 Funds	431,970	208,174	11,494	49,651	4
5	19	County Treasurer	Warrants	100,000	49 Funds	603,197	183,097	16,211	97,784	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,157,710	$ 1,378,000		$ 225,469	25

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McLean County Nursing Home COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0018150

CONTACT PERSON REGARDING THIS REPORT Donald Lee

TELEPHONE (309) 888-5380 FAX #: (309) 454-4594

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____YES _____NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,065 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1/1/1974	1974	$ 2,907,918	$ 72,695	40	$ 72,698	$ 3	$ 2,126,693	4
5			1/1/1975	1975	66,046	1,652	40	1,651	(1)	47,192	5
6			1/1/1976	1976	32,940	825	40	824	(1)	22,729	6
7											7
8											8
	Improvement Type**										
9	Paging System			12/07/89	2,588	129	20	129		1,807	9
10	Smoke Detectors			12/01/89	2,418		5			2,418	10
11	Air Cond & Boiler			11/30/79	40,718		40	1,018	1,018	28,177	11
12	Roof Repairs			06/29/82	3,374		40	84	84	1,764	12
13	Smoke Damper			07/01/83	3,600	180	40	90	(90)	1,890	13
14	Various - 1984			05/09/84	58,471	2,924	20	2,924		57,936	14
15	Fan Coil Units			04/13/84	1,158		15			1,158	15
16	Temp Sensors			02/13/85	499		10			499	16
17	Wood shed			07/01/85	749		15			749	17
18	Sewer Machine & 100 Gal Tank			04/30/86	1,592	60	20	80	20	1,377	18
19	Rear Door - Vestibule			01/26/84	1,962	49	40	49		980	19
20	Various - 1987			05/06/87	19,471	728	20	974	246	16,027	20
21	Concrete & Asphalt			06/16/87	19,249		10			19,249	21
22	Fire Doors			06/04/88	1,070	54	20	54		863	22
23	Replace Roof			08/16/88	481,262	26,515	18	26,737	222	401,055	23
24	Boiler Repairs			12/19/89	917		10			917	24
25	Masonry Repars - Bldg			10/05/89	5,521	221	25	221		3,093	25
26	Telephone System			01/01/88	4,250	170	25	170		2,720	26
27	Courtyard Repairs			05/23/89	2,191	83	20	110	27	1,540	27
28	Fire Alarm Control Panel			11/21/89	5,072		10			5,072	28
29	Capital Improvements			07/13/90	21,349	644	15	1,423	779	19,922	29
30	Capital Improvements			03/27/91	2,390	120	20	120		1,560	30
31	Heat Exchanger			03/21/91	2,236		10			2,236	31
32	Door Frame & Dining Room Remodel			05/29/92	6,350	173	40	159	(14)	1,793	32
33	Direct Cable - 500 Ft.			02/27/92	168	7	23	7		84	33
34	Closure & Power Frame Assembly			05/19/92	2,545		10			2,545	34
35	Boilers (2) & Stacks			10/07/92	63,200	3,160	20	3,160		34,760	35
36	Toilet Rails & Water Booster			06/29/93	2,585	172	15	172		1,807	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage Tank	11/08/93	$ 10,558	$ 211	50	$ 211	$	$ 2,141	37
38	Stairsteps	11/08/93	289	10	30	10		101	38
39	Air Cond & Boiler	11/30/80	9,889		20	494	494	5,434	39
40	Remodel Nurses Station	04/13/94	2,283	152	15	152		1,477	40
41	Air Cond Units (2)	07/19/94	79,305	5,287	15	5,287		49,973	41
42	IDPA Audit	01/01/92	4,243		10	3	3	4,243	42
43	Kitchen Walk-in Freezer/Cooler	10/30/96	11,038	552	20	552		3,958	43
44	Closed Circuit TV System-Recorder	02/27/98	3,208		5	100	100	3,208	44
45	NT System Wiring & Switches	12/22/98	4,222	844	5	825	(19)	4,222	45
46	Bathroom Improvements	08/19/99	9,505	951	10	951		4,190	46
47	Four Water Coolers	07/20/99	2,089	209	10	209		930	47
48	Aluminum Cubicle Track	09/10/99	7,578	379	20	379		1,632	48
49	Roofing Repairs	05/20/99	29,217	1,461	20	1,461	0	6,745	49
50	Cooridor Fire Doors	12/12/99	4,495	225	20	225		912	50
51	Time Clock System	07/13/99	7,144	476	15	476		2,127	51
52	Lamp Fixture Improvement	08/01/00	1,218	122	10	122		417	52
53	Room Remodeling Project 2000	12/31/00	39,599	2,700	15	2,640	(60)	7,920	53
54	Kitchen Disposal Unit	06/15/00	1,789	224	8	224		794	54
55	Room Remodeling Project 2000	01/01/01	40,993	2,956	15	2,733	(223)	8,191	55
56	Life Safety Project	10/22/01	12,937	866	15	862	(4)	1,828	56
57	Door Lock Project	03/28/01	31,078	2,072	15	2,072		5,722	57
58	Room Remodeling Project 2000	01/01/02	37,526	2,397	15	2,502	105	4,997	58
59	Kitchen Flooring	09/17/02	16,548	1,655	10	1,655		2,131	59
60	Generator Project	05/29/02	47,920	3,195	15	3,195		5,086	60
61	Administration Remodel	09/24/02	17,510	1,174	15	1,167	(7)	1,382	61
62	Paging System	09/12/02	3,217	280	15	214	(66)	279	62
63	Nurse's Station	05/13/03	1,403	62	15	59	(3)	59	63
64	Phase II Remodel - 300 Wing	11/18/03	13,354	74	15	105	31	105	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,214,015	$ 139,095		$ 141,739	$ 2,644	$ 2,940,816	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 647,168	$ 40,421	$ 40,421	$	various	$ 515,826	71
72	Current Year Purchases	92,030	2,452	2,452		various	2,452	72
73	Fully Depreciated Assets	154,774				various	154,774	73
74								74
75	TOTALS	$ 893,972	$ 42,873	$ 42,873	$		$ 673,052	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	Pick-up, '96 Dodge 4 x 4	01/18/96	$ 19,549	$ 226	$	$ (226)	5	$ 19,549	76
77	Patient Transport	Bus, '81 Ford	10/05/82	26,620				15	26,620	77
78	Maintenance	Tractor, Sears	09/30/96	3,509	439		(439)	5	3,509	78
79										79
80	TOTALS			$ 49,678	$ 665	$	$ (665)		$ 49,678	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,172,665	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,633	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,612	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,979	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,663,546	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	148	$ 9,048	$	148	$ 9,048	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		163	4,231		163	4,231	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		258	17,214		258	17,214	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				71,042		71,042	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					58,459		58,459	13
14	TOTAL			$	569	$ 30,493	$ 129,501	569	$ 159,994	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,802,042	$	1
2	Cash-Patient Deposits	18,825		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	555,676		3
4	Supply Inventory (priced at FIFO)	40,954		4
5	Short-Term Investments	1,050,440		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	492		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 4,468,429	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	4,180,902		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	795,984		16
17	Accumulated Depreciation (book methods)	(3,452,403)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 1,539,483	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 6,007,912	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (370,366)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(18,825)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(195,838)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (585,029)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (585,029)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (5,422,883)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (6,007,912)	$	48

*(See instructions.)

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 4,914,064	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 4,914,064	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	502,290	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Prior Period Adjustment	6,529	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 508,819	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 5,422,883	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1 Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (5,514,295)	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ (5,514,295)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(29,391)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(6,063)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ (35,454)	23
	D. Non-Operating Revenue		
24	Contributions	(336,816)	24
25	Interest and Other Investment Income***	(30,624)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ (367,440)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	(11,279)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ (11,279)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ (5,928,468)	30

	2 Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,330,994	31
32	Health Care	2,579,989	32
33	General Administration	1,120,936	33
	B. Capital Expense		
34	Ownership	182,633	34
	C. Ancillary Expense		
35	Special Cost Centers	129,501	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,426,178	40
41	Income before Income Taxes (line 30 minus line 40)**	(502,290)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (502,290)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,488	$ 76,751	$ 30.85	1
2	Assistant Director of Nursing	4,020	4,381	82,306	18.79	2
3	Registered Nurses	14,518	16,321	349,827	21.43	3
4	Licensed Practical Nurses	23,335	24,953	324,673	13.01	4
5	Nurse Aides & Orderlies	112,716	123,671	1,237,381	10.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,088	27,115	12.99	9
10	Activity Assistants	5,910	6,498	53,888	8.29	10
11	Social Service Workers	6,792	7,378	83,167	11.27	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,088	34,639	16.59	13
14	Head Cook	1,864	2,088	25,788	12.35	14
15	Cook Helpers/Assistants	27,263	29,677	235,183	7.92	15
16	Dishwashers					16
17	Maintenance Workers	6,711	7,432	113,154	15.23	17
18	Housekeepers	16,399	18,525	167,733	9.05	18
19	Laundry	11,361	11,689	108,770	9.31	19
20	Administrator	1,984	2,263	91,894	40.61	20
21	Assistant Administrator	1,629	2,088	31,564	15.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,603	6,344	90,849	14.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	1,999	2,246	21,290	9.48	33
34	TOTAL (lines 1 - 33)	247,829	272,217	$ 3,155,972 *	$ 11.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	282	$ 9,852	1.3	35
36	Medical Director		675	9.3	36
37	Medical Records Consultant	20	1,200	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,450	11.3	44
45	Social Service Consultant	27	1,450	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	356	$ 14,627		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	7,245	159,741	10.3	52
53	TOTAL (lines 50 - 52)	7,245	$ 159,741		53

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donald Lee	Administrator	-0-	$ 91,894
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,894

B. Administrative - Other

Description	Amount
County Administration Fee	$ 60,488
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 60,488

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Consulting	$ 49
Robert Rein, CPA	Consulting	7,438
Method Management NH	Consulting	1,875
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 9,362

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,032
Unemployment Compensation Insurance	
FICA Taxes	240,719
Employee Health Insurance	324,233
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	146,634
Employee Physicals	1,980
TOTAL (agree to Schedule V, line 22, col.8)	$ 748,597

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,127
Health Care Worker Background Check (Indicate # of checks performed 56)	
Life Services Network of Illinois	6,002
Nursing Books & Subscriptions	637
Other Dues	239
County Nursing Home Association	1,310
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,315

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,237
Seminar Expense	1,778
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,015

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2003 Ending: 12/31/200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of Illinois 6,002

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.8

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,299 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 82,125
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
Laundry & Housekeeping split on time spent.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 490

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: County Auditor The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit report not issued

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees